

Respondent argues the ALJ's finding of compensability is not supported by the preponderance of the credible evidence. Because claimant suffered multiple other life threatening preexisting conditions, any one of which could lead to death, the true cause of claimant's death cannot be stated within a reasonable degree of medical probability and certainty.

Claimant contends the ALJ's Award should be affirmed. Claimant maintains absolute certainty is not the required legal standard nor the medical standard for treating a patient, and the ALJ correctly held claimant satisfied his burden of proof with a preponderance of the evidence.

The sole issue for the Board's review is: Was claimant's death on February 28, 2011, a natural and probable consequence of his work injury of February 4, 2011?

FINDINGS OF FACT

Claimant was an employee of respondent for over 20 years as a park caretaker. On the afternoon of February 4, 2011, claimant slipped on some ice while at work, twisted his right ankle, and landed on his right knee. Claimant went home to his wife, Ruby Walker, and was unable to return to work. Ms. Walker testified claimant was confined to a recliner due to the pain in his right leg, and only left the recliner when absolutely necessary. Ms. Walker stated claimant slept in the recliner.

Three days later, on February 7, 2011, Ms. Walker stated she called an ambulance for claimant as he was unable to walk due to the ongoing pain in his right leg. Claimant presented at Coffeyville Regional Medical Center emergency room with complaints of pain in the right ankle and right knee. He reported he had fallen the previous Friday and had been in his chair all weekend. It was noted that "[u]pon admission, [claimant] was noted to have significant discomfort and edema of the right knee and right ankle. X-rays were negative. As [claimant] was unable to ambulate, he was admitted."¹

Claimant was admitted for secondary reasons, including pain control, physical therapy, a probable CT of the knee, and deep venous thrombosis (DVT) prophylaxis.² Claimant's medical condition was complicated by morbid obesity, hypertension, chronic pain, urethral stricture, abnormal bladder, obstructive sleep apnea on CPAP, poorly-controlled diabetes, Ehlers-Danlos syndrome, diabetic neuropathy, and degenerative arthritis with previous right hip and left knee replacements. Claimant was noted to be on multiple medications, including Lisinopril, Metformin, Crestor, Flexeril, Synthroid, and aspirin. Claimant's admission labs supported chronic kidney disease, chronic respiratory failure, anemia, and hypoalbuminemia.

X-rays of claimant's right ankle and right knee on February 7, 2011, did not reveal any fractures. Claimant's right hip prosthesis had no complications. It was determined claimant suffered a soft tissue injury to the right ankle and right knee which Dr. Patrick

¹ Flesher Depo., Ex. 3 at 1.

² It is not known whether claimant received DVT prophylaxis. There is no evidence in the record that documents administration of said prophylaxis.

Allen, claimant's treating physician at Coffeyville Regional, planned to treat with physical therapy and medication. On February 10, 2011, Dr. James Lin, a surgeon, was consulted due to progressive abdominal distention and vomiting. Dr. Lin diagnosed claimant with colonic ileus/Ogilvie's syndrome secondary to remote therapy and narcotic usage. No surgery was performed.

Claimant was not discharged from the hospital until February 17, 2011. During his time at the hospital, claimant was found to have excessive problems with sleep apnea. As a result, claimant was placed on BI-PAP, a type of oxygen apparatus. The Discharge Summary notes claimant "did very well. He was able to wean off his continuous BI-PAP over the next few days."³ Additionally, the ileus claimant developed while in the hospital was resolved before discharge. Further, claimant's shortness of breath resolved, and he was able to walk 90 feet with the assistance of a walker.

Claimant returned home but did not return to work. Ms. Walker testified claimant slept and spent most of the day in his recliner due to pain and swelling of his right leg. Claimant had been using nearly continuous CPAP with supplemental oxygen at home. Ms. Walker stated claimant was "hardly walking anymore," and "he was getting to where he couldn't urinate."⁴ She called for an ambulance on February 27, 2011, after claimant complained of abdominal pain. Ms. Walker stated that when EMTs arrived, claimant was awake and alert. After being laid flat on the stretcher, claimant suffered asystolic cardiac arrest. Claimant was resuscitated and intubated at the scene and transported to Coffeyville Regional Medical Center. Due to his critical condition, claimant was then transferred to Jane Phillips Medical Center in Bartlesville, Oklahoma, for further care. Claimant never regained consciousness.

On February 27, 2011, claimant was admitted to Jane Phillips Medical Center by Dr. William Patrick Tinker, a cardiologist. Claimant had evidence of "acute hypercapnic hypoxemic respiratory failure with refractory hypoxemia and acute renal failure."⁵ A cardiac evaluation was otherwise unremarkable, and there was no evidence by cardiac enzyme analysis of acute myocardial infarction (heart attack). Dr. Tinker felt the evidence was suggestive of a massive pulmonary embolus.

Dr. Tinker consulted with Dr. Mark Myers, a pulmonary medicine physician. Dr. Myers testified he referred to claimant's medical records during consultation as claimant was "critically ill, intubated, sedated, and actually on . . . paralytic agents by design."⁶

³ Estep Depo., Ex. 5 at 1.

⁴ R.H. Trans. at 21.

⁵ Myers Depo., Ex. 1 at 1.

⁶ Myers Depo. at 5.

Claimant's history was necessary in forming a diagnosis because at the time Dr. Myers examined claimant, he had suffered an otherwise unexplained out-of-hospital cardiopulmonary arrest. Dr. Myers' impression was that claimant sustained:

1. Out-of-hospital cardiopulmonary arrest: Differential diagnosis would include acute on chronic hypercapnic, hypoxemic respiratory failure from underlying obesity-hypoventilation syndrome with superimposed pneumonia or massive pulmonary embolism from his recent injury with high potential for deep venous thrombosis and PE [pulmonary embolism].
2. Left upper lobe health care-associated pneumonia.
3. Acute hypercapnic, hypoxemic respiratory failure with refractory hypoxemia.
4. Acute renal failure.
5. Morbid obesity with history of obstructive sleep apnea syndrome.⁷

Dr. Myers testified that due to claimant's multiple complications, he was not a candidate for a CT angiogram or ventilation perfusion lung scan. The only available options were a chest x-ray and a venous Doppler study.

The venous Doppler study showed a DVT of the right popliteal vein, located behind the right knee. Dr. Myers noted that claimant was "not considered to be a candidate for thrombolytic therapy due to an unacceptably high likelihood of significant hemorrhage. Therefore, [claimant] was treated presumptively for pulmonary thromboembolic disease with anticoagulant therapy."⁸ Claimant continued to have difficulties with refractory hypoxemia and progressive hypotension. Claimant sustained complete cardiovascular collapse and death on February 28, 2011.

Dr. Myers stated he considers DVT and pulmonary embolism to be different components of the same disease along a spectrum. Dr. Myers opined his diagnosis of pulmonary embolism is strongly supported by the fact claimant had a DVT. In his letter of April 16, 2012, Dr. Myers opined that based upon a reasonable degree of medical certainty, claimant's cause of death was very compatible with a massive pulmonary embolism that originated from a right lower extremity DVT. Further, it is Dr. Myers' opinion within a reasonable degree of medical certainty that claimant's on-the-job injury and subsequent immobility was the most glaring risk factor in claimant's DVT and pulmonary embolism.

Claimant's death certificate lists his cause of death as pulmonary embolism as a consequence of DVT. However, there was no autopsy of claimant's body and no other imaging study that can confirm a pulmonary embolism.

⁷ Myers Depo., Ex. 2 at 4.

⁸ Myers Depo., Ex. 1 at 2.

Dr. Edward J. Prostic, an orthopedic surgeon, reviewed the medical records and death certificate at claimant's counsel's request. In his report of March 6, 2013, Dr. Prostic noted:

In context, this quite obese gentleman who had had previous right total hip replacement arthroplasty was predisposed to thrombophlebitis of his right lower extremity. With immobilization following the right lower extremity injury at work on or about February 4, 2011, he developed thrombophlebitis with pain and swelling of his right lower extremity. Unfortunately, this was not recognized during his hospitalization at Coffeyville. Because of his medical status and extensive weight, CT angiography was not performed to prove his pulmonary embolus. The information available to me indicates that the work-related injury to the right lower extremity set about the chain of events that led to the death of [claimant].⁹

Dr. Prostic was aware of claimant's other health issues; however, after reviewing all available records, Dr. Prostic opined claimant's cause of death was "with greater than 50 percent probability . . . a pulmonary embolus."¹⁰

Dr. Dennis Estep, an occupational environmental medicine physician, reviewed claimant's medical records to offer a causation opinion at respondent's request. While Dr. Estep agreed claimant could have died from a pulmonary embolism due to a DVT, he stated that was an assumption. Dr. Estep could not state within a reasonable degree of medical probability that claimant died from a pulmonary embolism. Further, assuming claimant did have a pulmonary embolism, there is no way to tell from which part of the body the DVT originated. In light of claimant's multiple risk factors for DVT, including obesity, immobilization, and prior musculoskeletal procedures, Dr. Estep opined:

[T]he work-related injury which [claimant] sustained on February 5, 2011 [sic] was an aggravation to his underlying disease process. His underlying disease process is the prevailing cause of his difficulty while in the hospital. The second admission and subsequent death of [claimant], it is my opinion that work is not a prevailing cause nor is this an aggravation. It is my opinion that this is due to underlying disease process as the prevailing cause.¹¹

Dr. Estep would not offer a cause of death as he felt there were too many possibilities and too few tests performed to arrive at a definitive opinion.

Dr. John Flesher, a pulmonologist, also reviewed claimant's records at respondent's request. As no autopsy was performed on claimant's body, Dr. Flesher stated, "[T]here are

⁹ Prostic Depo., Ex. 2 at 1-2.

¹⁰ Prostic Depo. at 18.

¹¹ Estep Depo., Ex. 2 at 4.

many potential causes of shock and there are a number of his chronic medical conditions that could have led to that shock state, so I don't know that we can ascertain which one of those it was."¹² Dr. Flesher agreed pulmonary embolism is one possible cause of claimant's death. However, with claimant's other risk factors and poor health, Dr. Flesher testified he does not know if there is enough evidence in the record for him to state definitively the cause of claimant's death. He further noted:

Though [claimant] was at very high risk for venous thromboembolism, it does not appear, from the medical records that I have, that he was prescribed prophylactic treatment for this condition for the bulk of his initial hospital course, nor during his convalescence at home. Ultimately, this was felt to be the cause of his death. I can say with a reasonable degree of medical certainty that, while his fall contributed to a brief period of immobility, it was [claimant's] poor state of health that ultimately led to his demise.¹³

Dr. Flesher stated he has at times determined the cause of death without an autopsy, but only when he is absolutely certain of the cause of death. He cannot say within a reasonable degree of medical certainty the cause of claimant's death.

PRINCIPLES OF LAW

In proceedings under the Workers Compensation Act, the burden of proof is on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions upon which the claimant's right depends.¹⁴ "Burden of proof" means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true.¹⁵ To persuade by the preponderance of the evidence requires the claimant to demonstrate the greater weight of evidence in view of all the facts and circumstances.¹⁶

It is well-established in workers compensation law that, when a primary injury under the Workers Compensation Act is shown to have arisen out of and in the course of

¹² Flesher Depo. at 10.

¹³ Flesher Depo., Ex. 2 at 2.

¹⁴ K.S.A. 2010 Supp. 44-501(a). *Matney v. Matney Chiropractic Clinic*, 268 Kan. 336, 995 P.2d 871 (2000).

¹⁵ K.S.A. 2010 Supp. 44-508(g).

¹⁶ *In re Estate of Robinson*, 236 Kan. 431, 620 P.2d 1383 (1984).

employment, the natural consequences directly flowing from the injury, including new and distinct injuries, are compensable.¹⁷

ANALYSIS

The Board agrees with the ALJ that the weight of the evidence supports the conclusion that claimant's death is causally related to his leg injury. The opinions of the treating physician should carry more weight than the other physicians'. Dr. Myers was the only physician who physically examined claimant when he was alive.

The other doctors were limited to a medical record review and did not have the benefit of examining claimant. Dr. Estep does not practice and has no demonstrable training or experience practicing pulmonary medicine. Dr. Estep testified he did not review the hospital records from after the initial injury until after he wrote his causation letter. Dr. Estep is not qualified to provide an expert opinion on this issue.

Dr. Flesher is a pulmonary medicine specialist. Dr. Flesher agreed that pulmonary embolism was a possible cause of death. Dr. Flesher agreed that claimant had a variety of risk factors that make him prone to DVT, including the traumatic injury, immobility and a variety of personal health conditions. The crux of Dr. Flesher's opinions is that he does not know what caused claimant's death.

When claimant was admitted to the Jane Phillips Medical Center the day before his death, Dr. Tinker suspected a massive pulmonary embolism related to his injury three weeks prior. Dr. Tinker ordered a bilateral lower extremity venous Doppler study, which confirmed a DVT in the right leg.

Dr. Myers testified claimant's risk factors for DVT from his first examination of claimant in 2002, prior to February 2011, were claimant's weight and sleep apnea. He also stated the claimant's pneumonia, which was present at the time he was admitted prior to his death, was a risk factor. Dr. Myers added that the pneumonia could have resulted from aspiration when resuscitating claimant prior to his admission. He stated that diabetes was not a risk factor for venous disease.

Dr. Myers opined the DVT strongly suggested claimant suffered a pulmonary embolism. He testified his opinion was based on the totality of the findings and the fact that DVT and pulmonary embolism are part of the same disease. Dr. Myers stated that, within a reasonable degree of medical certainty, the slip and fall injury led to the DVT,

¹⁷ *Stockman v. Goodyear Tire & Rubber Co.*, 211 Kan. 260, 263, 505 P.2d 697 (1973); *Logsdon v. Boeing*, 35 Kan. App. 2d 79, 85, 128 P.2d 430 (2006).

which is a “surrogate marker of a high degree of pulmonary embolism.”¹⁸ Ultimately, Dr. Myers concluded that the work-related injury led to a pulmonary embolism that caused claimant’s death. The Board agrees.

The Board also agrees with the ALJ that claimant failed to present sufficient evidence to determine what portion of the expenses incurred were related to the work-related injury. In proceedings under the Workers Compensation Act, it is claimant's burden to prove his entitlement to benefits by a preponderance of the credible evidence.¹⁹ There is no evidence in the record that delineates related and unrelated medical services.

CONCLUSION

The ALJ did not err in finding claimant’s death on February 28, 2011, was a natural and probable consequence of his work injury of February 4, 2011. Claimant failed to present evidence to establish the relationship of the medical bills to the work-related injury.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Bruce E. Moore dated June 26, 2013, is affirmed.

IT IS SO ORDERED.

Dated this _____ day of November, 2013.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

¹⁸ Myers Depo. at 19.

¹⁹ See K.S.A. 2010 Supp. 44-501 and K.S.A. 2010 Supp. 44-508(g).

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